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Introduction to the 32 Chief Complaint Types

TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> f. Because of the vascular nature of the face and scalp, lacerations to these areas may appear to be serious bleeds. Remember to focus on controlling the bleeding rather than estimating volume of blood loss. g. Patients on blood-thinning drugs or those with hemophilia should be considered higher priority, life-threatening events and receive a higher level response. h. The primary focus of the EMD should be on control of external bleeding, identifying symptoms indicating the onset of shock and airway maintenance of the unconscious patient. <p>2. Common Causes:</p> <ul style="list-style-type: none"> a. Self explanatory for external bleeding. b. Internal bleeding can be caused by trauma, chronic or acute gastrointestinal ulcerative disease, gynecological/obstetric maladies and ruptured abdominal aortic aneurysms. <p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none"> a. Blood squirting out or pulsating out are common descriptions of external arterial bleeding. b. Internal bleeding can be manifested as coffee ground-like emesis (vomit), blood in the emesis, dark tarry stools (indicating upper GI bleeds) or blood in the stools (indicating a lower GI bleed). 	<p><TG PAGE 3-49></p>

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<p>c. Anxiety, lowered levels of consciousness, agitation, chills, along with other classic symptoms of shock, are often reported in association with serious bleeds.</p> <p>4. Instructions Commonly Provided:</p> <p>a. Monitor and maintain patient's airway if level of consciousness is decreased.</p> <p>b. Use direct pressure for all external lacerations. If the bleeding does not stop, the caller should apply more pressure to the bleeding site.</p> <p>c. Treat for shock:</p> <p>1) Lay patient on left side (recovery position) EXCEPT IN SPINAL INJURY SITUATIONS.</p> <p>2) Keep patient warm.</p> <p>3) DO NOT GIVE PATIENT FOOD OR DRINK.</p> <p>d. For nose bleeds instruct the caller to pinch the nose between the thumb and finger and apply pressure in this way. Have the patient sit forward and attempt to spit the blood out (swallowing it will make the patient nauseous).</p> <p>e. Call back if the patient's condition changes before help arrives.</p> <p>f. Lock all pets away because they may interfere with instructions given or attack responding personnel.</p>	<p><TG PAGE 3-50></p>

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<p>5. Special Pediatric Considerations:</p> <ul style="list-style-type: none"> a. Lacerations or hemorrhages in the head and facial areas in children may be serious bleeds because children have a smaller total circulating blood volume than adults and because these areas are very well supplied with blood and make up a larger portion of the body than in adults. <p>8 - Industrial Accidents (Traumatic Incident Type)</p> <p>1. Background:</p> <ul style="list-style-type: none"> a. The purpose of this protocol is to identify what the situation is, where the patient is, if the patient is trapped in machinery and direct the caller to have someone meet and guide the responding personnel to the patient. b. These cases should be handled as case specific, and if the chief complaint can be identified the EMD may go to a more appropriate protocol for the provision of pre-arrival instructions. c. These calls are most often third party calls. d. Enclosed spaces present grave danger where chemicals or gases may be present. These are most common in industrial or farm settings. The offending agent may not be obvious. Rescue should only be attempted by trained rescue personnel. 	<p>Point out that head wounds in children are more serious.</p> <p><TG PAGE 3-51></p> <p>Review the Industrial Accidents complaint type.</p> <p>Point out the dangers of enclosed spaces.</p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>2. Common Causes:</p> <ul style="list-style-type: none">a. Industrial traumatic incidents and entrapments in machineryb. Common medical incident types such as abdominal pain, chest pain, diabetic problems, etc.c. Reaction or exposure to chemicals or gases in the environment. <p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none">a. Case specific. Often all that is known is that an ambulance is needed at a particular location. <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none">a. Advise callers not to go into enclosed spaces to retrieve or treat the victim due to the possible presence of noxious or dangerous fumes.b. The call often comes in from a security office or factory medical clinic. If the call comes from the security office of some location remote from the patient, it is very important to have them direct someone to meet the responders and guide them to the patient.c. Case specific pre-arrival instructions should be given if the chief complaint is identified.d. If the patient is trapped in machinery the machinery should be shut off.e. Do not move the patient or splint the injuries.	<p><TG PAGE 3-52></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> f. Control of external bleeding with direct pressure and treat for shock if symptoms are present. g. Obtain and relay pertinent information regarding previous medical history and cause of incident if possible. h. Treat for shock: <ul style="list-style-type: none"> 1) Control bleeding. 2) Lay patient on left side (recovery position) EXCEPT IN SPINAL INJURY SITUATIONS. 3) Keep patient warm. 4) DO NOT GIVE PATIENT FOOD OR DRINK. i. Lock all pets away because they may interfere with instructions given or attack responding personnel. <p>5. Special Pediatric Considerations: NONE</p>	<p><TG PAGE 3-53></p>
<p>9 - Stabbing/Gunshot Victim (Traumatic Incident Type)</p> <ul style="list-style-type: none"> 1. Background: <ul style="list-style-type: none"> a. This protocol deals with penetrating trauma of any kind. b. Penetrating trauma to the extremities is not as serious as penetrating trauma to the torso (or central core). Penetrating traumas below the knees and elbows are not as serious as those above these areas of the extremities. 	<p>Review the Stabbing/Gunshot complaint type.</p>

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<ul style="list-style-type: none">c. The safety of the scene is critical to determine and relay to the responding personnel.d. The EMD should attempt to determine if there is a weapon at the scene or if the assailant is nearby.e. The EMD should also determine when the incident occurred. <p>2. Common Causes:</p> <ul style="list-style-type: none">a. Self-explanatory <p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none">a. Callers reporting these incidents often have an emotional response to the situation. Proper calming techniques should be used.b. Visible external bleeding.c. Multiple victims.d. Unconscious patient. <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none">a. Advise callers to remain safe. Do not approach scene if the assailant is presumed to be present.b. Monitor and maintain patient's airway, especially if patient is nauseated or vomiting or if the level of consciousness is decreased.c. Use direct pressure to control external bleeding.	<p><TG PAGE 3-54></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">d. Treat for shock:<ul style="list-style-type: none">1) Control bleeding.2) Lay patient on left side (recovery position) EXCEPT IN SPINAL INJURY SITUATIONS.3) Keep patient warm.4) DO NOT GIVE PATIENT FOOD OR DRINK.e. Do not pull out penetrating objects.f. Do not disturb the scene or remove weapons.g. Gather or list the patient's medication for the doctor.h. Call back if the patient's condition changes before help arrives. <p>5. Special Pediatric Considerations:</p> <ul style="list-style-type: none">a. A child with a penetrating injury is highly likely to require surgery. Make sure that children in your system have access to a facility with staff (emergency department, surgeon, anesthesiologist, nursing, intensive care unit, laboratory, etc.) familiar with critically ill or injured children, as well as the means to get there in a timely fashion.	<p><TG PAGE 3-55></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>10 - Traumatic Injuries (Traumatic Incident Type)</p> <ol style="list-style-type: none">1. Background:<ol style="list-style-type: none">a. This protocol is used for specific, identifiable injuries.b. The focus of this protocol is to keep the patient still and to provide information so as to not cause any further injury to the patient.2. Common Causes:<ol style="list-style-type: none">a. Fractures, dislocations, minor contusions and abrasions, etc.b. Falls resulting in some specific trauma other than to the back.3. Common Symptoms Described by Caller (presentation)<ol style="list-style-type: none">a. Fractures, pain and swelling, immobility.b. Back pain, numbness, tingling or immobility of the extremities. In this case a spinal injury should be assumed and spinal precautions taken.c. External bleeding.4. Instructions Commonly Provided:<ol style="list-style-type: none">a. Monitor and maintain patient's airway, especially if patient is nauseated or vomiting or if the level of consciousness is decreased.	<p>Review the Traumatic Injuries complaint type.</p> <p><TG PAGE 3-56></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> b. Treat for shock: <ul style="list-style-type: none"> 1) Control bleeding. 2) Lay patient on left side (recovery position) EXCEPT IN SPINAL INJURY SITUATIONS. 3) Keep patient warm. 4) DO NOT GIVE PATIENT FOOD OR DRINK. c. Do not move the patient or splint any injuries. d. Call back if the patient's condition changes before help arrives. e. Lock all pets away because they may interfere with instructions given or attack responding personnel. 5. Special Pediatric Considerations: <ul style="list-style-type: none"> a. The alert injured child should be kept with a familiar adult if possible. b. Injuries which look like sprains in children may involve the noncalcified portion of the bone called the "growth plate." If the growth plate of a particular bone is injured, there may be a difference in final bone length or growth compared with the other side. Children who complain of hip, groin, or knee pain after a trivial injury may have a slippage of the bone through the growth plate of the femur (thigh bone). Further weight bearing may increase the slippage. Such children should be kept off their feet until evaluated even though they may be able to bear weight. 	<p><TG PAGE 3-57></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>11 - Vehicle Related Injuries (Traumatic Incident Type)</p> <ol style="list-style-type: none"> 1. Background: <ol style="list-style-type: none"> a. This protocol is used in cases of injury caused by vehicles like automobile collisions, auto-pedestrian incidents, auto-motorcycle and bicycle collisions. b. Due to the third party nature of these calls information regarding how many patients, if there are any visible injuries, and the mechanisms of the accident are helpful to elicit from the caller and relay to the responding personnel. c. Additional information of use includes if any one has been thrown from the vehicle or if there is chemical spill involved. If a chemical spill has occurred this information should be relayed, along with the type of chemical involved, to HAZMAT personnel. d. Often motor vehicle collisions resulting in serious injury or death are treated as crime scenes. Check with your local regulations about what to do about these situations. 2. Common Causes: <ol style="list-style-type: none"> a. Self explanatory. 	<p>Review the Vehicle Related Injuries complaint type.</p> <p><TG PAGE 3-58></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none"> a. Multiple calls for the same collision. Callers may offer different accounts of the accident. Dispatch of appropriate resources should follow established in-house operating procedures. b. Multiple patients, patients thrown, roll-overs and numerous other descriptions of the like. c. Auto-pedestrian, auto-motorcycle and auto-bicycle collisions should always be considered high level emergencies. <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none"> a. Treat for shock: <ul style="list-style-type: none"> 1) Control bleeding. 2) Lay patient on left side (recovery position) EXCEPT IN SPINAL INJURY SITUATIONS. 3) Keep patient warm. 4) DO NOT GIVE PATIENT FOOD OR DRINK. b. Do not move the patient(s) unless they are in danger. c. Do not splint any injuries. d. Ensure that the patient(s) have an open airway and monitor the patient's level of consciousness. e. Call back if the patient's condition changes before help arrives. 	<p><TG PAGE 3-59></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">f. Treat collision as potential crime scene until law enforcement arrives. Check with local regulations on how to deal with collision crime scenes.g. Lock all pets away because they may interfere with instructions given or attack responding personnel. <p>5. Special Pediatric Considerations:</p> <p>Vehicle-Child injuries will tend to be worse than Vehicle-Adult injuries for the following reasons:</p> <ul style="list-style-type: none">a. children tend to turn and face the on-coming car (resulting in frontal injuries) while adults tend to turn away (resulting in less life-threatening back injuries) andb. children's height tends to put their vital organs at the same level as the bumper of the approaching vehicle, making the resulting injuries that much worse.c. If multiple family members are involved in a vehicle crash, it is helpful to be able to transport the child with at least one familiar adult family member if possible.d. Policies for extrication of children in car seats should reflect the most recent NHTSA guidelines.	<p><TG PAGE 3-60></p>

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<p>Individual Chief Complaint Protocols. Following is a detailed review of the fourteen Individual Chief Complaint protocols. Your instructor will provide additional information about these, and then you will be given the opportunity to practice using your local EMDPRS for the protocol that corresponds to the chief complaint.</p>	<p><TG PAGE 3-61></p> <p>Review each of the following Individual Chief Complaint protocols.</p> <p>We suggest you review each individual chief complaint type by going over the:</p> <ol style="list-style-type: none">1. background;2. common causes;3. common symptoms reported;4. instructions usually given and5. any special pediatric considerations the EMD should know. <p>Once you've reviewed these points (for <u>each</u> complaint type), review EMDPRS protocols for the members of your class.</p> <p>If trainees represent many different agencies, you might consider using multiple instructors and breaking the class into groups where EMDPRSs can be reviewed individually.</p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>2. Common Causes:</p> <ul style="list-style-type: none"> a. Most critical causes of abdominal pain include: <ul style="list-style-type: none"> 1) myocardial infarction (symptoms include high abdominal pain (like indigestion); 2) abdominal aortic aneurism (symptoms include abdominal pain associated with back pain, sweating, fainting, symptoms of shock, dizziness) and 3) ectopic pregnancy (lower abdominal pain; signs of shock and may or may not have missed a period). b. Moderately serious causes of abdominal pain include simple appendicitis, bowel obstruction (usually found in the elderly), perforated gastric ulcers, kidney stones and chronic illnesses involving the abdominal organs. c. Least critical causes of abdominal pain include gastritis, gastroenteritis, pelvic inflammatory disease, gastric ulcers, flu type maladies and gas. <p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none"> a. Sharp stabbing pains, localized or covering the abdomen generally. b. Abdominal distention or bloating. c. Nausea, vomiting, diarrhea. 	<p><TG PAGE 3-63></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">d. Pallor, sweating, fainting, light-headedness. <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none">a. Monitor and maintain patient's airway, especially if patient is nauseated or vomiting.b. Allow patient to assume a comfortable position.c. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD.d. Treat for shock:<ul style="list-style-type: none">1) Keep airway clear.2) DO NOT GIVE FOOD OR DRINK.3) Let patient assume a position of comfort.4) Calm and reassure patient.5) Keep the patient warm (maintain body temperature).e. Gather or list the patient's medication for the doctor.f. Call back if the patient's condition changes before help arrives.g. Lock all pets away because they may interfere with instructions given or attack responding personnel.	<p><TG PAGE 3-64></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>5. Special Pediatric Considerations:</p> <p>a. Abdominal pain in the pediatric patient is rarely a symptom of a critical event. It is worth considering three special situations that require rapid response.</p> <ol style="list-style-type: none"> 1) Parents will sometimes attribute persistent irritability or crying in their infant to abdominal pain and may contact EMS out of alarm or because they can no longer tolerate the crying. Irritable or colicky infants may be at increased risk of child abuse. 2) Young boys with torsion (twisting) of the testicle may report only abdominal pain (either because the pain is referred to the abdomen or out of modesty). Failure to reverse the testicular torsion rapidly and restore the blood supply may result in the loss of reproductive function in that testicle. 3) Because infants and children cannot always describe or communicate their symptoms, moderately serious causes of abdominal pain may not receive attention as quickly as they might in an adult, and may therefore be complicated by shock, peritonitis, and bowel necrosis (tissue death). <p>b. Moderately serious causes of abdominal pain in children include appendicitis (often ruptured before diagnosed in young children), kidney stones or bowel obstruction like intussusception (telescoping of the bowel on itself) or volvulus (twisting of the bowel on itself). Vomiting that is green or yellow may contain bile and should be considered a</p>	<p><TG PAGE 3-65></p>

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<p>critical symptoms and not try to determine the cause of the reaction.</p> <p>b. Individuals are most commonly allergic to bee stings and other insect bites, seafood (particularly shellfish), nuts, berries and medication such as injected penicillin.</p> <p>3. Common Symptoms Described by Caller (presentation)</p> <p>a. In more severe cases the caller may report sudden collapse, difficulty breathing and/or swallowing, excessive salivation, unconsciousness and respiratory arrest.</p> <p>b. Anaphylactic shock may have some or all of the symptoms mentioned in 3.a. These symptoms will occur within one hour of the exposure in most cases.</p> <p>c. Minor symptoms may include a rash, swelling, hives, itching, abdominal pain and nausea. If these symptoms have been present for over one hour they are very unlikely to progress into anaphylaxis.</p> <p>d. <i>If the caller reports that the patient has a history of allergies and has had these reactions before, believe them!</i> They may indicate that the patient has been provided a self injectable medication, usually adrenalin or epinephrine. The EMD should tell the caller to have the patient "do what the doctor told you to do".</p>	<p style="text-align: center; vertical-align: middle;"><TG PAGE 3-67></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none">a. Monitor and maintain patient's airway, especially if patient is showing redness and/or swelling around the eyes, nose and mouth or having difficulty breathing or swallowing or has a decreasing level of consciousness.b. If the patient's condition seems to be worsening, keep the caller on the phone and be prepared to initiate telephone CPR.c. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD.d. Treat for shock:<ul style="list-style-type: none">1) Keep airway clear.2) DO NOT GIVE FOOD OR DRINK.3) Let patient assume a position of comfort.4) Calm and reassure patient.5) Keep the patient warm (maintain body temperature).e. Unconscious patients should be placed on their side and their airways maintained. The EMD should constantly monitor the patient's airway and breathing status if the patient becomes unconscious.f. The EMD should tell the caller to have the patient "do what the doctor told you to do".g. Gather or list the patient's medications for the doctor.	<p><TG PAGE 3-68></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> h. Call back if the patient's condition changes before help arrives. i. Lock all pets away because they may interfere with instructions given or attack responding personnel. <p>5. Special Pediatric Considerations:</p> <ul style="list-style-type: none"> a. Respiratory symptoms from allergic reactions can progress very rapidly in children to partial or complete airway obstruction and respiratory arrest, because their smaller airways can become obstructed with smaller degrees of swelling. Unsuspected allergic reaction to a sting or food item can be the cause of sudden unconsciousness in the child. <p>3 - Back Pain (Individual Chief Complaint)</p> <p>1. Background:</p> <ul style="list-style-type: none"> a. The incidence of non-traumatic back pain is very common and in most cases represents minor problems. There are some critical situations that can be identified with proper questioning from the EMD using the EMDPRS. b. Often a patient experiencing a cardiac event such as myocardial infarction (M.I.) will describe the pain as radiating through to their back. 	<p>Review the Back Pain chief complaint.</p> <p><TG PAGE 3-69></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">c. Patients over the age of 50, complaining of lower back pain with no history of injury or chronic back problems or if they are exhibiting signs of shock should be considered to be experiencing abdominal aortic aneurysms and be treated as an emergency.d. Back pain may be described as either acute or chronic. In either case the key to a proper response is determining the age, history and symptoms the patient is presently exhibiting, particularly identifying the existence of chest pain (in patients over 35) or fainting (in patients over 50).e. The severity of the pain and the duration of the pain often does not relate to the severity of the problem. <p>2. Common Causes:</p> <ul style="list-style-type: none">a. Most critical causes of back pain include falls, abdominal aortic aneurysms, thoracic dissections, neurologic problems and M.I.b. Moderately serious causes of back pain include kidney stones, rib and spinal fractures (if traumatically induced).c. Least critical causes of back pain include chronic low back pain, vertebral disc disease, kidney infections and sprained backs. <p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none">a. Sharp stabbing pains, localized or covering the abdomen generally.	<p><TG PAGE 3-70></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> b. Abdominal distention or bloating. c. Nausea, vomiting, diarrhea. d. Pallor, sweating, fainting light-headedness. e. Numbness or tingling in the extremities. <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none"> a. Monitor and maintain patient's airway, especially if patient is nauseous or vomiting. b. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD. c. Treat for shock: <ul style="list-style-type: none"> 1) Keep airway clear. 2) DO NOT GIVE FOOD OR DRINK. 3) Let patient assume position of comfort (IN CASES OF TRAUMATIC BACK PAIN, THE PATIENT SHOULD NOT BE MOVED); 4) Calm and reassure patient and 5) Keep the patient warm (maintain body temperature). d. Gather or list the patient's medications for the doctor. e. Call back if the patient's condition changes before help arrives. f. Lock all pets away because they may interfere with instructions given or attack responding personnel. 	<p style="text-align: center;"><TG PAGE 3-71></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>5. Special Pediatric Considerations: - NONE</p> <p>4 - Breathing Problems (Individual Chief Complaint)</p> <p>1. Background:</p> <ul style="list-style-type: none"> a. Breathing problems are usually more severe in the very young and the very old. b. Often a patient experiencing a cardiac event such as myocardial infarction (M.I.) will complain of difficulty breathing. c. Breathing problems should always be considered a high level medical emergency. d. The previous medical history should be relayed to the responding units. <div style="border: 1px solid black; padding: 10px; margin-top: 20px;"> <p>NOTE: People who call you reporting breathing problems represent one of the most difficult calls you will have to deal with. What may be one person's distress could be another's chronic breathing problem (that they have to deal with daily).</p> <p>What's most important is that you try to determine what has changed about the person's breathing that prompted the caller to call for help.</p> </div>	<p>Review the Breathing Problems complaint type.</p> <p><TG PAGE 3-72></p> <p>Tell trainees that breathing problem calls represent the most difficult calls they will receive.</p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>2. Common Causes:</p> <ul style="list-style-type: none"> a. Primary breathing problems having to do with the lungs (lower respiratory system) include asthma, pneumonia, drug overdose, emphysema, pulmonary embolus, congestive heart failure and acute pulmonary edema. b. Secondary breathing problems having to do with the upper airway include croup, choking, epiglottitis and partial airway obstructions. c. Tertiary breathing problems caused by an unrelated illness or incident include hyperventilation syndrome, stroke (CVA), diabetic ketoacidosis, seizures, cardiac arrest, and in some cases severe facial trauma. <p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none"> a. Difficulty breathing, wheezing, shortness of breath, noisy breathing, "fighting for air," gasping for air, etc. b. Anxiety, change in skin color, impending feeling of "impending doom." c. Excessive coughing. <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none"> a. Monitor and maintain patient's airway, especially if patient is nauseous or vomiting. 	<p style="text-align: center;"><TG PAGE 3-73></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">b. Calm and reassure the patient. Tell the patient to relax and slow their breathing, blow the air out and encourage the patient to breath with you.c. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD.d. Treat for shock:<ul style="list-style-type: none">1) Keep airway clear.2) DO NOT GIVE FOOD OR DRINK.3) Let patient assume position of comfort (usually sitting-up).4) Calm and reassure patient.5) Keep the patient warm (maintain body temperature).e. Gather or list the patient's medication for the doctor.f. Call back if the patient's condition changes before help arrives.g. Lock all pets away because they may interfere with instructions given or attack responding personnel.	<p><TG PAGE 3-74></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>5. Special Pediatric Considerations:</p> <p>a. <i>Breathing problems are the most common pediatric medical problem encountered by the EMD and can be critical. Air passages are smaller than in the adult, and therefore problems will be more acute. Airway obstruction happens more commonly in infants and children than in adults. Infants may not learn to breath through their mouths until as late as nine months of age, therefore, simple nasal congestion of a cold is capable of causing significant respiratory distress in the infant. In addition to the signs and symptoms listed above, consider the presence of head bobbing, grunting (a sound made in expiration with each breath) flaring of the nostrils and retracting of the skin with each breath at the clavicles, ribs and diaphragm as signs of advancing respiratory distress.</i></p> <p>b. Although the incidence of epiglottitis has marked declined since the use of a vaccine to prevent the usual bacteria responsible, it remains a true respiratory emergency. The hallmark presenting sign is usually marked throat pain to the point of being unable to swallow (drooling), fever and rapidly progressing respiratory distress in a febrile child who assumes a "tripod" sitting position with his/her neck flexed and head extended (the "sniffing" position). The child with suspected epiglottitis, and all children with suspected upper airway obstruction, should be allowed to assume the position of comfort, kept calm, not separated from his or her parent and brought to medical attention as soon as possible.</p>	<p><TG PAGE 3-75></p>

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<p>5 - Chest Pain (Individual Chief Complaint)</p> <p>1. Background:</p> <ul style="list-style-type: none">a. Chest pain often is caused by a blockage of one or more of the coronary arteries. This blocks the oxygen delivery to a portion of the heart muscle and causes chest pain.b. Often a patient experiencing a cardiac event such as myocardial infarction (M.I.) will describe the pain as in their upper abdomen.c. The average age of the onset of symptomatic cardiac disease is 35 years old for males and 40 years for females. Any male patient 35 or older or female 40 or older complaining of abdominal pain should be considered a possible cardiac event.d. Any patient over the age of 35 complaining of chest pain should be considered a cardiac event.e. Patients with prior histories of cardiac problems may represent a higher critical problem. <p>2. Common Causes:</p> <ul style="list-style-type: none">a. Most critical causes of chest pain include heart attack (myocardial infarction or M.I.) and a dissecting thoracic aortic dissection (aneurism in the chest).	<p>Review the Chest Pain complaint type.</p>

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<ul style="list-style-type: none">b. Allow patient to assume a comfortable position, usually sitting up to aid in respirations.c. The patient may report that they have been given medication to take when they experience chest pain. If they ask the EMD what they should do, the EMD should advise the caller to have the patient do what their doctor told them to do. If the patient has taken any medication, this information should be relayed to the responding units.d. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD.e. Treat for shock:<ul style="list-style-type: none">1) Keep airway clear.2) DO NOT GIVE FOOD OR DRINK.3) Let patient assume position of comfort.4) Calm and reassure patient.5) Keep the patient warm (maintain body temperature).f. Have first-party callers stay on the phone, or if the patient has an altered level of consciousness, or if callers state that they feel as if they "are going to die."g. Gather or list the patient's medications for the doctor.h. Call back if the patient's condition changes before help arrives.	<p><TG PAGE 3-78></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">i. Lock all pets away because they may interfere with instructions given or attack responding personnel. <p>5. Special Pediatric Considerations:</p> <ul style="list-style-type: none">a. Chest pain is a common symptom in young adolescents, but unusual in younger children and when present is extremely unlikely to be due to myocardial infarction. Spontaneous pneumothorax, air leak from an acute asthmatic attack, and pulmonary embolus do occur in the pediatric population.b. Because it is not commonly recognized, pulmonary embolus has a much higher case fatality rate in children than in adults. The child with chest pain, fast heart and breathing rate and any of the following can be considered at risk for pulmonary embolus:<ul style="list-style-type: none">1) obesity2) birth control pills3) dehydration4) nephrotic syndrome5) family history of clotting problems6) recent long bone fracture and7) prolonged bedrest or inactivity.	<p style="text-align: center;"><TG PAGE 3-79></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>6 - Convulsion/Seizure (Individual Chief Complaint)</p> <ol style="list-style-type: none"> 1. Background: <ol style="list-style-type: none"> a. A convulsion or seizure is believed to be caused by a misfiring of nerve cells in the brain either as a result of injury, lack of oxygen or disease. b. Patients going into cardiac arrest occasionally will have a brief, anoxic seizure due to the brain being robbed of oxygen. It is often an initial sign of cardiac arrest. Seizure patients over 35 whose breathing cannot be verified should be considered cardiac arrests until breathing can be confirmed. c. There are many types of seizures including grand mal, petit mal, psychomotor, focal motor and jacksonian. All present themselves in a different fashion. The most common by far is the grand mal. d. Ninety-five percent of all seizure patients with an unknown history have been diagnosed with epilepsy. e. Seizures associated with fever (febrile seizures) in children under 6 are common. They are usually short in duration (less than 15 minutes), self-limited, and rarely cause respiratory or cardiac compromise. It is unusual for febrile seizures to require medication in the field and they do not indicate that the child has epilepsy. f. CPR should not be performed on a seizure patient unless the pulse is not present. 	<p>Review the Convulsion/Seizure complaint type.</p> <p><TG PAGE 3-80></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> g. Once the seizure has stopped, maintaining an open and clear airway is the most important thing the EMD can do for the seizure patient. h. Most seizures last approximately 45-60 seconds. Anoxic seizures resulting from cardiac arrest are usually much shorter. After the seizure stops, the patient is normally unconscious and in what is referred to as a "post-ictal" state. This condition usually last less that 15 minutes and may be longer for some patients. Once the seizure has ended, the patient experiences excessive salivation and may have a great deal of oral secretions. This is the time when airway maintenance is crucial. i. Patients reported to be having continuous or multiple seizures represent a much higher medical emergency. j. Some epileptic patients can tell when they are going to have a seizure and may have someone call for help before the seizure starts. This is called an aura. <p>2. Common Causes:</p> <ul style="list-style-type: none"> a. Epilepsy, trauma to the head, brain or intra-cranial tumors, meningitis, cardiac arrest, anoxia (lack of oxygen), fever, and many other causes. Anything that disrupts the normal functioning of the brain has the potential to cause a seizure. 	<p style="text-align: center;"><TG PAGE 3-81></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>3. Common Symptoms Described by Caller: (presentation)</p> <ul style="list-style-type: none">a. Sudden stiffening and jerking movements over the entire body. The caller may describe the patient as arching their back and perhaps crying out just before the seizure.b. Bluish or discoloration of the skin during seizure.c. Snoring or gurgling after the seizure is over. This indicates a possible compromise in the airway. <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none">a. Monitor and maintain patient's airway after the seizure. Gently roll the patient on their side and clear out the mouth to clear the airway.b. Do not attempt to hold the patient down during the seizure.c. Do not perform CPR while the patient is jerking.d. Do not attempt to place anything in the mouth while patient is seizing to prevent them from biting or "swallowing" the tongue.e. Do not let the patient get up or wander around after the seizure, as they may not be fully conscious.f. Move dangerous objects away from the patient during the seizure to prevent injury.	<p><TG PAGE 3-82></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">g. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD.h. Treat for shock:<ul style="list-style-type: none">1) Keep airway clear.2) DO NOT GIVE FOOD OR DRINK.3) Let patient assume position of comfort.4) Calm and reassure patient.5) Keep the patient warm (maintain body temperature).i. Gather or list the patient's medications for the doctor.j. Call back if the patient's condition changes before help arrives.k. Lock all pets away because they may interfere with instructions given or attack responding personnel. <p>5. Special Pediatric Considerations:</p> <ul style="list-style-type: none">a. Seizures in children are common and a common reason for calling EMS. Although many childhood seizures will be found to be simple febrile seizures, epilepsy is common in childhood.b. Status epilepticus is a series of consecutive seizures or continuous seizure activity in which the child does not regain consciousness between seizures.	<p style="text-align: center;"><TG PAGE 3-83></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">c. Prolonged seizures can cause brain damage, especially if associated with either low blood and brain levels of glucose and oxygen.d. Seizure activity may be subtle, and can look like limpness, eye rolling or blinking, chewing or mouthing motions, cycling movements of the legs, as well as the more easily identified tonic-clonic shaking of extremities. It is helpful for the bystander and the EMS providers to note any asymmetry of movement, including eye deviation.	
<p>7 - Diabetic Problems (Individual Chief Complaint)</p> <ul style="list-style-type: none">1. Background:<ul style="list-style-type: none">a. Diabetes is a condition that prevents the body from correctly metabolizing sugar into energy. The body lacks the ability to produce correct amounts of insulin, the hormone that aids in sugar metabolism. This requires the diabetic patient, in many cases, to have to take insulin.b. When a diabetic fails to take their insulin they will have a gradual rise in their blood sugar levels. This is a slow onset and results in diabetic ketoacidosis. Ketoacids are a toxic byproduct of this. The body tries to eliminate these toxins through the respiratory system, and the patient may be described as breathing very deeply. The ketoacids can be detected on the patients breath as a fruity or sweet smell. The patient may become very ill	<p>Review the Diabetic Problems complaint type.</p> <p><TG PAGE 3-84></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>with flu like symptoms. If this goes unchecked the patient may progress into diabetic coma, a state of unconsciousness caused by extremely high blood sugar levels. Patients often seek medical attention prior to this occurring.</p> <p>c. When an insulin dependent diabetic takes too much insulin or takes their regular dose and engages in higher levels of activity or fails to eat, the insulin depletes the body's available blood sugar, and the patient experiences a rapid decrease in consciousness. This condition is known as insulin shock. It has a rapid onset with the level of consciousness decreasing until the patient is unconscious. This is by far the most common diabetic emergency faced by EMS.</p> <p>d. Due to the high reliability of the family's reporting of an insulin reaction or diabetic problem, this protocol should be accessed if the caller indicates that it is a diabetic emergency.</p> <p>e. The main thing for the EMD to be concerned with is maintaining the patients airway if their level of consciousness is decreased.</p> <p>f. The EMD should attempt to obtain and relay information regarding the history of the patient.</p> <p>2. Common Causes:</p> <p>a. As noted previously.</p> <p>3. Common Symptoms Described by Caller (presentation)</p> <p>a. As noted previously.</p>	<p><TG PAGE 3-85></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none">a. Monitor and maintain patient's airway, especially if patient's level of consciousness is decreased or if they are unconscious.b. Allow patient to assume a comfortable position.c. Administration of sugar or soda-pop to a diabetic patient is left up to local medical control. This is because doing so alters the assessment of the patient by responding personnel and may not have any noticeable effect on the patient's level of consciousness. <i>You need to check your local regulations on the administration of sugar to diabetics.</i>d. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD.e. Treat for shock:<ul style="list-style-type: none">1) Keep airway clear.2) DO NOT GIVE FOOD OR DRINK.3) Let patient assume position of comfort.4) Calm and reassure patient.5) Keep the patient warm (maintain body temperature).f. Gather or list the patient's medications for the doctor.g. Call back if the patient's condition changes before help arrives.	<p><TG PAGE 3-86></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>h. Lock all pets away because they may interfere with instructions given or attack responding personnel.</p> <p>5. Special Pediatric Considerations:</p> <p>a. Some children with diabetes have been provided with glucagon, a medication which can be given as a shot to raise blood sugar if the child becomes unconscious or begins seizing with insulin shock. If the caller is able to administer glucagon during such episodes, the EMD should advise that it be given "as your doctor has directed you."</p> <p>8 - Headache (Individual Chief Complaint)</p> <p>1. Background:</p> <p>a. Since the brain is the organ of concern in patients reporting headache the primary focus of the EMD should be changes in the patient's alertness (level of consciousness) and speech and motor problems. Both indicate more serious causes.</p> <p>b. Sudden severe onset of pain may suggest a more serious underlying cause as well (subarachnoid and subdural hemorrhage).</p> <p>c. Most other headaches such as migraine, tension, sinus etc. are less serious in nature. EMS is not commonly called for these complaints.</p>	<p>Review the Headache complaint type.</p> <p><TG PAGE 3-87></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>2. Common Causes:</p> <ul style="list-style-type: none">a. Most serious causes of headaches include: meningitis; subdural hematomas and subarachnoid hemorrhage. These are usually reported as having started as a sudden severe onset of pain and are often associated with speech and/or motor problems.b. Moderately serious causes include migraines, cluster and other vascular headaches.c. Minor causes of headaches include tension, sinus headaches (the common headache) and intracerebral bleeding due to hypertension. <p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none">a. Sudden severe onset of pain associated with speech or motor problems should be considered more serious than a simple complaint of headache without any other symptoms.b. History of migraines. The patient may be nauseated and vomiting and be incapacitated with pain. <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none">a. Monitor and maintain patient's airway, especially if patient is nauseated or vomiting.b. Allow patient to assume a comfortable position.c. Do not give the patient anything to eat or drink.	<p><TG PAGE 3-88></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> d. Gather or list the patient's medications for the doctor. e. Call back if the patient's condition changes before help arrives. f. Lock all pets away because they may interfere with instructions given or attack responding personnel. <p>5. Special Pediatric Considerations:</p> <ul style="list-style-type: none"> a. Meningitis is more common in children than adults and is potentially contagious. If the symptoms described include fever, respiratory precautions should be advised for the EMS team dispatched. 	
<p>9 - Heart Problems (Individual Chief Complaint)</p> <p>1. Background:</p> <ul style="list-style-type: none"> a. This complaint represents a diagnosis rather than a chief complaint. The EMD must concentrate on looking for symptoms from the caller rather than a presumed diagnosis. b. The EMD should attempt to determine if chest pain is present and then proceed to the appropriate protocol for that specific chief complaint. c. The EMD should attempt to gain information regarding previous medical or cardiac history. The patient may have an implanted defibrillator or pacemaker that has malfunctioned. These complaints may not always be associated with classic cardiac symptoms. 	<p>Review the Heart Problems complaint type.</p> <p><TG PAGE 3-89></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">d. If, after all questioning, the patient is without symptoms, the EMD may attempt to have the caller get a pulse rate on the patient. Many heart problems are manifested by a rapid heart rate. An adult with a resting heart rate of over 140 may be having a heart problem. Slow heart rates can cause decreased consciousness. Any heart rate less than 40 is also cause for concern.e. Congestive heart failure may present itself as breathing difficulty, weakness, sweating and the caller may report to you that the patient has been on typical heart medications (like diuretics). <p>2. Common Causes:</p> <ul style="list-style-type: none">a. Electrical malfunctions of the heart resulting in irregular or rapid heart rates.b. Acute myocardial infarction.c. Malfunctioning internal defibrillators. <p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none">a. Firing internal defibrillator.b. Chest pain, difficulty breathing and other cardiac related symptoms.c. Irregular or rapid heart rate. Often described as "palpitations". <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none">a. Monitor and maintain patient's airway, especially if patient is nauseated or vomiting.	<p><TG PAGE 3-90></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> b. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD. c. Treat for shock: <ul style="list-style-type: none"> 1) Keep airway clear. 2) DO NOT GIVE FOOD OR DRINK. 3) Let patient assume position of comfort. 4) Calm and reassure patient. 5) Keep the patient warm (maintain body temperature). d. Gather or list the patient's medications for the doctor. e. Call back if the patient's condition changes before help arrives. f. Lock all pets away because they may interfere with instructions given or attack responding personnel. 5. Special Pediatric Considerations: <ul style="list-style-type: none"> a. Common causes of pediatric heart problems include congenital abnormalities of the heart that can cause congestive heart failure or cyanosis and rhythm disturbances, particularly very fast heart rates above 200. Symptoms in the infant and child include those mentioned, as well as poor feeding and change in color or activity level. 	<p style="text-align: center;"><TG PAGE 3-91></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>10 - Ingestions/Poisons/O.D. (Individual Chief Complaint)</p> <ol style="list-style-type: none"> 1. Background: <ol style="list-style-type: none"> a. An overdose, as defined for dispatch, is a purposeful and intentional ingestion involving any patient over the age of 12 years old. The patient also has a motive for their actions. b. An accidental ingestion is defined as an accidental, or unintentional, intake by a child under the age of 12. c. A poisoning is defined as an accidental intake of a toxic substance, usually by a child under the age of 12. d. All overdose patients should be considered a possible danger to themselves and others. The safety of the scene must be addressed during questioning. e. Access to the local poison control intervention line should be established and accessed, when appropriate, according to local policies and procedures. 2. Common Causes: <ol style="list-style-type: none"> a. Accidental ingestions at home are common in children and the elderly (confusion with medication). b. Overdoses are related to depression, either as a gesture for help or as a serious suicide attempt. 	<p>Review the Ingestions/Poisons/O.D. complaint type.</p> <p><TG PAGE 3-92></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> c. Poisonings occurring in the home usually involve a small child who has ingested a family member's medications or some toxic/caustic substance. 3. Common Symptoms Described by Caller (presentation) <ul style="list-style-type: none"> a. Normally described as noted previously. 4. Instructions Commonly Provided: <ul style="list-style-type: none"> a. Monitor and maintain patient's airway, especially if patient is nauseated or vomiting or if the level of consciousness is decreased. b. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD. c. Treat for shock: <ul style="list-style-type: none"> 1) Keep airway clear. 2) Let patient assume position of comfort. 3) Calm and reassure patient. 4) Keep the patient warm (maintain body temperature). d. In cases of poisoning, do not induce vomiting. If caustic ingestion, have patient drink water or milk until help arrives (CHECK WITH POISON CONTROL CONSULTANTS FIRST, UNLESS OTHERWISE INDICATED IN YOUR EMDPRS). e. Do not give the patient anything to eat or drink except in cases of a caustic ingestion of an acid or lye. 	<p style="text-align: center;"><TG PAGE 3-93></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">f. Protect the patient from further injury to themselves if safe to do so.g. Contact poison control if ingestion is accidental and the patient is free of symptoms.h. Call back if the patient's condition changes before help arrives or if the patient leaves the scene.i. Lock all pets away because they may interfere with instructions given or attack responding personnel. <p>5. Special Pediatric Considerations:</p> <ul style="list-style-type: none">a. Poisoning is the most common cause of non-fatal injury in the home. The most common serious poisonings in children involve caustics, hydrocarbon/petroleum, iron (medicinal), antidepressant and cardiac medications.	
<p>11 - Psychiatric/Behavioral (Individual Chief Complaint)</p> <p>1. Background:</p> <ul style="list-style-type: none">a. Psychiatric or behavioral problems can relate to a diagnosed problem such as schizophrenia, mania, depression, etc.b. Underlying medical problems often are mistaken for behavioral problems. In diabetics or epileptics, their lowered level of consciousness during or after manifestation may be mistaken for a psychiatric or behavioral problem. Attempt to determine medical history.	<p><TG PAGE 3-94></p> <p>Review the Psychiatric/Behavioral complaint type.</p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> c. All patients exhibiting psychiatric/behavioral problems should be considered a potential danger to themselves and others. d. It should be determined if the patient has a weapon. e. If the patient has attempted suicide, the specific EMDPRS chief complaint protocol should be accessed in the EMDPRS and followed to treat the reported situation. f. The EMD may want to check if resources exist for crisis intervention. <p>2. Common Causes:</p> <ul style="list-style-type: none"> a. As described previously. <p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none"> a. Patient exhibiting abnormal or unusual behavior. b. Patient threatening violence. c. Patient threatening suicide. d. Depression. <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none"> a. Monitor and maintain patient's airway, especially if patient is nauseated or vomiting or if the level of consciousness is decreased. b. Attempt to protect the patient from themselves. 	<p style="text-align: center;"><TG PAGE 3-95></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">c. Attempt to lay the patient down and calm him/her.d. Do not give the patient anything to eat or drink.e. Gather or list the patient's medication for the doctor.f. Call back if the patient's condition changes or if the patient leaves the scene before help arrives.g. If available, Crisis Intervention should be contacted. Check with your agency about local regulations on using Crisis Intervention.h. Lock all pets away because they may interfere with instructions given or attack responding personnel <p>5. Special Pediatric Considerations:</p> <ul style="list-style-type: none">a. In children under 8, many episodes of altered behavior of possible psychiatric origin will in fact be related to underlying toxic exposure, neurologic event or infection, or child abuse.	
<p>12 - Sick Person (Individual Chief Complaint)</p> <p>1. Background:</p> <ul style="list-style-type: none">a. A sick person is a patient who has an undefinable chief complaint, uncategorizable symptoms or when the caller provides specific information on a previous diagnosis.	<p><TG PAGE 3-96></p> <p>Review the Sick Person complaint type.</p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> b. This card is accessed when a second party caller reports a diagnosis or some other term to describe what they believe may be the problem. c. The function of this protocol is to assist the EMD in identifying the chief complaint or some other significant symptom or medical history, rather than rely on the caller's presumed diagnosis. <p>2. Common Causes:</p> <ul style="list-style-type: none"> a. Any illness or malady could potentially be handled on this protocol. <p>3. Common Symptoms Described by Caller: (presentation)</p> <ul style="list-style-type: none"> a. Callers often will relate a previous diagnosis. b. Nausea, vomiting, weakness, dehydration. c. These patients have the potential to be very ill, as in the case of a terminally ill patient. Calm and reassure the caller who may have had an emotional response to the situation. d. If a specific chief complaint is identified the EMD should use the EMDPRS protocol that suits the patient's chief complaint. <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none"> a. Monitor and maintain patient's airway, especially if patient is nauseated or vomiting or if the level of consciousness is decreased. 	<p style="text-align: center;"><TG PAGE 3-97></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">b. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD.c. Treat for shock:<ul style="list-style-type: none">1) Keep airway clear.2) DO NOT GIVE FOOD OR DRINK.3) Let patient assume position of comfort.4) Calm and reassure patient.5) Keep the patient warm (maintain body temperature).d. Gather or list the patient's medications for the doctor.e. Call back if the patient's condition changes before help arrives.f. Lock all pets away because they may interfere with instructions given or attack responding personnel <p>5. Special Pediatric Considerations:</p> <ul style="list-style-type: none">a. Children with a pre-existing diagnosis are much more likely than healthy children to have a medical event requiring EMS. Some agencies maintain a roster of children in the community with special or pre-existing health care needs whose safety network relies upon a knowledgeable EMS system familiar with the child's condition, usual complications, emergency treatment, and usual site of emergency and chronic care. Parents and	<p><TG PAGE 3-98></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>caregivers of such children have frequently been equipped with such information and can assist EMS in such situations.</p> <p>b. It can be difficult to tell whether a child is having an emergency or not. The younger the child, the more vague or nonspecific may be the signs of illness; irritability, crying, vomiting, fever, and lethargy are symptoms that may accompany a wide range of pediatric conditions, many trivial, some life-threatening. Behind the complaint "something is wrong with my child" ("sick, hurt, crying") may be an unsuspected foreign body in the esophagus, intussusception, meningitis, child abuse, or a simple ear infection. Behind the complaint, "my baby had a spell where she was blue, pale, not breathing, unresponsive..." may be something as simple as regurgitation or as complex as seizure, heart rhythm disturbance, apnea or sepsis. Because the symptoms are nonspecific, even the experienced pediatric provider will sometimes have difficulty discriminating between these conditions in person, let alone over the phone. Over-triage is an acceptable response to this ambiguity.</p>	<p style="text-align: center;"><TG PAGE 3-99></p>
<p>13 - Stroke/CVA (Individual Chief Complaint)</p> <p>1. Background:</p> <p>a. A stroke, or cerebral vascular accident (CVA) denotes a situation where the blood flow has been interrupted to a portion of the brain due to a blood clot, hypertension-induced intracerebral hemorrhage or a ruptured aneurysm.</p>	<p>Review the Stroke/CVA complaint type.</p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> <ul style="list-style-type: none"> b. Although dramatic, the CVA patient usually is not considered a high level medical emergency. The event is fixed, therefore the treatment is rehabilitative. 2. Common Causes: <ul style="list-style-type: none"> a. Blockage of a cerebral artery. b. Ruptured aneurysm. c. Dissecting aneurysm. d. Intracerebral hemorrhage. 3. Common Symptoms Described by Caller (presentation) <ul style="list-style-type: none"> a. Speech and motor problems. Motor functions diminish on one side of the body. b. Numbness and tingling may be present. c. History of stroke. d. Altered level of consciousness (lower levels of consciousness indicate the event is more severe). 4. Instructions Commonly Provided: <ul style="list-style-type: none"> a. Monitor and maintain patient's airway, especially if patient is nauseated or vomiting or if the level of consciousness is decreased. b. Allow patient to assume a comfortable position. c. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD. 	<p style="text-align: center;"><TG PAGE 3-100></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>d. Treat for shock:</p> <ol style="list-style-type: none"> 1) Keep airway clear. 2) DO NOT GIVE FOOD OR DRINK. 3) Let patient assume position of comfort. 4) Calm and reassure patient. 5) Keep the patient warm (maintain body temperature). <p>e. Gather or list the patient's medications for the doctor.</p> <p>f. Call back if the patient's condition changes before help arrives.</p> <p>g. The patient may have difficulty walking, do not let them wander around (they could injure themselves further).</p> <p>h. Lock all pets away because they may interfere with instructions given or attack responding personnel</p> <p>5. Special Pediatric Considerations:</p> <ol style="list-style-type: none"> a. Symptoms suggestive of a stroke are not common in healthy children but can rarely occur for all the same reasons as in an adult, or because of a complicated migraine. Children with underlying medical conditions like leukemia, renal failure, hemophilia, or metabolic disease are at risk for CVAs. Whoever is attending the child must pay particular attention to the airway in the child. 	<p><TG PAGE 3-101></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>14 - Unknown/Man Down (Individual Chief Complaint)</p> <ol style="list-style-type: none">1. Background:<ol style="list-style-type: none">a. These calls are usually third party calls reporting an unknown situation or a man down and appearing to need assistance.b. The third party nature of these cases makes it difficult to get valid, comprehensive information from the caller about the patient's condition.c. The questions should help to determine if the patient is alive or not. The third party caller can report if the patient was sitting or standing or lying down and if the patient was seen talking or moving at all to help clarify this question.2. Common Causes:<ol style="list-style-type: none">a. Intoxication, trauma, underlying medical complaints.b. Virtually anything causing the patient to fall and not get up would be handled with this protocol if the caller was a third party (away from the scene and patient).3. Common Symptoms Described by Caller (presentation)<ol style="list-style-type: none">a. Man down in the park etc., caller not near the patient and little information available.b. Medical assist alarms.	<p>Review the Unknown/Man Down complaint type.</p> <p><TG PAGE 3-102></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none"> a. Return to the patient and establish consciousness, airway and breathing. Monitor and maintain patient's airway, especially if patient is nauseated or vomiting or if the level of consciousness is decreased. b. Ask the caller if there is a phone or person closer to the patient that could be used (so you can get better information). c. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD. d. Treat for shock: <ul style="list-style-type: none"> 1) Keep airway clear. 2) DO NOT GIVE FOOD OR DRINK. 3) Let patient assume position of comfort; 4) Calm and reassure patient. 5) Keep the patient warm (maintain body temperature). e. Watch for and guide the ambulance to the patient. f. Call back if the patient's condition changes before help arrives. g. Lock all pets away because they may interfere with instructions given or attack responding personnel 	<p><TG PAGE 3-103></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>5. Special Pediatric Considerations:</p> <p>a. Unsuspected allergic reaction should be considered.</p> <p>Time/Life-Critical Events. Following is a detailed review of the seven Time/Life Critical Events. Your instructor will provide additional information about these, and then you will be given the opportunity to practice using your local EMDPRS for the protocol that corresponds to the chief complaint.</p>	<p><TG PAGE 3-104></p> <p>Review each of the following Time/Life-Critical Events.</p> <p>We suggest you review each event by going over the:</p> <ol style="list-style-type: none">1. Background2. common causes;3. common symptoms reported4. instructions usually given;5. any special pediatric considerations the EMD should know. <p>Once you've reviewed these points (for <u>each</u> time/life-critical event), review EMDPRS protocols for the members of your class.</p> <p>If trainees represent many different agencies, you might consider using multiple instructors and breaking the class into groups where EMDPRS can be reviewed individually.</p>

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TRAINEE TEXT

INSTRUCTOR NOTES

1 - CO/Inhalation/HAZMAT (Time/Life-Critical Event)

Review the CO/Inhalation/HAZMAT complaint type.

1. Background:

- a. The purpose of this protocol is to identify what the situation is, where the patient is, if the patient is trapped in machinery and direct the caller to have someone meet and guide the responding personnel to the patient.
- b. These cases should be handled as case specific, and if the chief complaint can be identified the EMD may go to a more appropriate protocol for the provision of pre-arrival instructions.
- c. These calls are most often third-party calls.
- d. Enclosed spaces present grave danger where chemicals or gases may be present. These are most common in industrial or farm settings. The offending agent may not be obvious. Rescue should only be attempted by trained rescue personnel.
- e. CO is a colorless odorless gas that is the result of incomplete combustion.
- f. Carbon monoxide (CO) poisoning is the most common hazardous material/inhalation complaint encountered in EMS.

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>g. CO binds with the hemoglobin molecule in the blood stream and displaces oxygen and carbon dioxide. This makes this complaint very urgent in that the patient is possibly suffocating at the cellular level. More severe cases of CO poisoning may require hyperbaric treatment in a decompression chamber in order to provide sufficient energy to break these chemical bonds.</p> <p>h. Patients can be found in any stage of intoxication. One of the most telling symptoms is the level of consciousness. If the patient is unconscious or has a decreased level of consciousness, they should be assumed to have a severe exposure and immediate transport should be advised.</p> <p>i. Other inhalation and HAZMAT situations present should also be assumed to be high level emergencies. The EMD should determine the source and type of exposure and advise the caller to remain safe and away from the hazardous environment. If information regarding the type and source of the exposure is obtained, it must be relayed to the responding crews.</p> <p>2. Common Causes:</p> <p>a. CO poisoning resulting from smoke inhalation, poorly ventilated heating systems, industrial accidents and automobile exhaust systems.</p> <p>b. Most other HAZMAT incidents occur in industrial settings or on the highway, secondary to motor vehicle accidents involving chemical spills. The EMD should be aware of local HAZMAT policies in these cases.</p>	<p><TG PAGE 3-106></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none">a. Headache, nausea and altered level of consciousness are common CO poisoning complaintsb. In cases of other inhalations and HAZMAT situations, callers may report respiratory difficulty, burning of the eyes, superficial chemical burns, nausea, vomiting and decreased levels of consciousness.c. Multiple victims are commonly present if in an industrial or public location. <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none">a. Remove patient from hazardous environment if safe to do so.b. Monitor and maintain patient's airway, especially if patient is described with a decreased level of consciousness or is unconscious.c. Irrigate chemical exposures to the skin with water if burns are present.d. Enclosed spaces present grave danger where chemicals or gases may be present. These are most common in industrial or farm settings. The offending agent may not be obvious. Rescue should only be attempted by trained rescue personnel.e. Be aware that the patient may have difficulty walking. Discourage ambulation (Don't let them walk around).	<p><TG PAGE 3-107></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">f. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD.g. Treat for shock:<ul style="list-style-type: none">1) Keep airway clear.2) DO NOT GIVE FOOD OR DRINK.3) Let patient assume position of comfort.4) Calm and reassure patient.5) Keep the patient warm (maintain body temperature).h. Have someone guide the responding personnel to the patient(s) if in an industrial setting.i. Call back if the patient's condition changes before help arrives.j. Lock all pets away because they may interfere with instructions given or attack responding personnel <p>5. Special Pediatric Considerations:</p> <ul style="list-style-type: none">a. CO/inhalation events occur in pediatric aged patients usually in a situation with poorly ventilated home heating, prolonged car travel, or house fires. CO poisoning has been implicated in crib death or Sudden Infant Death Syndrome (SIDS). If the exposure involves multiple victims, there may be variable levels of exposure and symptoms. It is helpful to have specific plans or protocols for the transfer of children to hyperbaric treatment facilities.	<p><TG PAGE 3-108></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>b. HAZMAT situations involving children are uncommon, but may involve multiple children if located at a school or day care facility. Any HAZMAT disaster planning should have provisions specific to the management of single or multiple affected children.</p> <p>2 - Cardiac Arrest (Time/Life-Critical Event)</p> <p>1. Background:</p> <p>a. Cardiac arrest occurs when the heart ceases to product a productive rhythm, hence no blood is circulated. Respiratory arrest (stopped breathing) usually accompanies cardiac arrests. In this state patients are defined as "clinically dead."</p> <p>b. Patients in cardiac arrest who have CPR initiated early and continued throughout the response have a better chance for survival.</p> <p>c. All patients who are reported to be unconscious and not breathing or who's breathing cannot be verified by a second party caller should be assumed to be in cardiac arrest.</p> <p>d. A system of consistent and uniform questioning should be used on all calls to determine if the patient is conscious and breathing and to determine cardiac arrest as soon as possible.</p> <p>e. Be certain to determine pulselessness during CPR instruction sequence to avoid chest compressions on patients who are in respiratory arrest only.</p>	<p>Review the Cardiac Arrest complaint type.</p> <p><TG PAGE 3-109></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>f. Always determine if the patient has choked on something prior to doing CPR. They may need choking instructions to clear the upper airway obstruction.</p> <p>2. Common Causes:</p> <p>a. Ventricular fibrillation, acute myocardial infarction, trauma, chronic illness, electrocution, suffocation, drowning, choking.</p> <p>3. Common Symptoms Described by Caller (presentation)</p> <p>a. Patient unconscious and not breathing, unresponsive.</p> <p>b. Patient's color has changed.</p> <p>c. Patient described as "making funny or strange noises" (a term used by callers to describe agonal or dying respirations).</p> <p>1) Agonal respirations are breaths that occur after cardiac arrest and are ineffective in gathering oxygen for the body. They are frequently described as "weak," "heavy," "gasping," "snoring," "gurgling" or "moaning." The rate at which these respirations occur are usually referred to as "weak or heavy," "occasional" or "every once in a while."</p> <p>4. Instructions Commonly Provided:</p> <p>a. Follow CPR or Choking instructions found in EMDPRS to provide telephone instructions to the caller.</p>	<p><TG PAGE 3-110></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">b. Lock all pets away because they may interfere with instructions given or attack responding personnel <p>5. Special Pediatric Considerations:</p> <ul style="list-style-type: none">a. Unlike adults, children develop cardiac arrest from a multitude of different causes, 10% of which or less having to do with primary heart problems. You will not commonly deal with pediatric cardiac arrest. When you are called upon to do so, it is helpful to realize that some children presumed to be in full cardiac arrest have respiratory arrest only and that recovery from respiratory arrest can be excellent if effective airway support and rescue breathing are begun as soon as possible. It can be very difficult to feel a pulse in infants or small children and there should be as little delay as possible in providing airway support and rescue breathing.b. The child in full cardiac arrest has most commonly been suffering some period of oxygen deprivation and/or and circulatory failure and the outcome of resuscitative efforts is usually very poor. Unlike in adults, timely defibrillation will not often change the outcome of pediatric cardiac arrest. Moreover, basic life support units equipped with semiautomatic defibrillators will usually have weight or age limitations on the use of the equipment. Critical interventions in a pediatric cardiac arrest are airway and breathing management and circulatory support. Units responding to a pediatric cardiac arrest ideally should be skilled in advanced airway management and vascular or intraosseous access.	<p><TG PAGE 3-111></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>Recommendations for instructions for bystander CPR for children are different than for adults. These differences should be conveyed in specific neonatal, infant and child CPR protocols.</p> <p>3 - Choking (Time/Life-Critical Event)</p> <p>1. Background:</p> <ul style="list-style-type: none">a. Upper airway obstruction constitutes a life critical emergency requiring immediate intervention by the EMD.b. Often the only chance for survival of the patient is for the EMD to assist via telephone choking instructions.c. Patients with a total upper airway obstruction are not able to breathe, speak or cough.d. Unless the airway is cleared of the blockage the patient will become unconscious within 1-2 minutes and irreversible brain damage and death will occur in 4-6 minutes.e. Choking instructions given over the telephone by trained EMDs are one of the most common life-saving interventions undertaken by the EMD.f. A patient who has gagged or has a partial airway obstruction should not have choking instructions provided. If the patient is able to make any sounds through the airway, the patient should not be agitated. If the patient has a cough that seems to be addressing the problem, don't intervene. If the patient	<p>Review the Choking complaint type.</p> <p><TG PAGE 3-112></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>appears to be deteriorating, then something should be done. Signs of a partial obstruction are high-pitched wheezing or whistling sounds.</p> <p>2. Common Causes:</p> <ul style="list-style-type: none"> a. Choking on food and small toys (in children) are the most common causes of upper airway obstructions. b. Some situations such as asthma, epiglottitis and severe allergic reactions may appear to be choking episodes. <p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none"> a. The patient may have grabbed his/her throat to signal a choking episode. b. The patient's color is blue or has changed from it's normal color. c. The patient may be unconscious. d. The patient may be reported to have been eating. <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none"> a. Follow Choking instruction sequence found in EMDPRS to provide telephone instructions to the caller. b. Be sure to avoid performing chest compressions by ascertaining status of pulse during the choking treatment instructions. c. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD. 	<p style="text-align: center;"><TG PAGE 3-113></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">d. Treat for shock:<ul style="list-style-type: none">1) Keep airway clear.2) DO NOT GIVE FOOD OR DRINK.3) Let patient assume position of comfort.4) Calm and reassure patient.5) Keep the patient warm (maintain body temperature).e. Do not attempt choking interventions on patients who do not have a complete airway obstruction (cannot talk, breathe or speak).f. Gather or list the patient's medications for the doctor.g. Keep caller on the phone until help arrives and takes over from the bystanders.h. Repeat choking sequence until help arrives or until the airway is cleared.i. Call back if the patient's condition changes before help arrives.j. Lock all pets away because they may interfere with instructions given or attack responding personnel.	<p><TG PAGE 3-114></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>5. Special Pediatric Considerations:</p> <ul style="list-style-type: none"> a. Choking on foreign bodies is a common pediatric problem and one for which pediatricians frequently give safety advice to parents. Small toy parts, latex balloons, mercury batteries and solid food pieces are common causes. b. The child who has recovered from a significant choking episode should be evaluated for the possibility of a foreign body that has been aspirated into the lower airway (gone into the body of the lung). c. Foreign bodies in the esophagus of young children can sometimes cause choking and respiratory compromise. d. Recommendations for instructions for management of choking are different in infants, children and adults. These differences should be conveyed in specific neonatal, infant and child CPR protocols. 	
<p>4 - Drowning (possible) (Time/Life-Critical Event)</p> <p>1. Background:</p> <ul style="list-style-type: none"> a. This protocol is intended to be used in those cases of near-drowning incidents ("drowning" is death due to immersion, whereas "near-drowning" is survival from such an event). b. If the patient is in cardiac arrest, the EMD should identify the unconsciousness and not breathing status and proceed directly to instructions for CPR. 	<p><TG PAGE 3-115></p> <p>Review the Drowning complaint type.</p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>c. In cases of shallow water diving incidents, the presence of a cervical spinal injury must always be assumed as a possibility. Care should be taken to not move the patient unless absolutely necessary.</p> <p>d. In cases of near-drowning, the patient is often found in respiratory arrest only and not in cardiac arrest. This means that frequently, if the patient is discovered quickly, the patient needs only ventilatory support. The EMD must carefully check for pulselessness prior to initiating CPR.</p> <p>e. Resuscitation efforts should be undertaken with all victims of near-drowning. No one knows how long a patient can be under water and be successfully resuscitated. There have been documented saves of victims that have been underwater for over an hour.</p> <p>f. A theory explains that this phenomenon is related to the mammalian diving reflex. Most aquatic mammals are able to exist for long periods of time underwater on lowered levels of oxygen. It is believed that the younger the patient, the longer they can be submerged due to the holdover vestige of the patient's pre-birth disposition where they lived in an aquatic environment on lowered levels of oxygen. Combined with the cold temperature of the water in many cases, the salvageability of the patient is enhanced.</p>	<p><TG PAGE 3-116></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>2. Common Causes:</p> <ul style="list-style-type: none">a. Bathtub drownings, pools, ponds and canals (particularly with children).b. Shallow water diving incidents resulting in spinal cord injury. <p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none">a. Coughing, difficulty breathing, lowered levels of consciousness, vomiting and change in skin color.b. With possible spinal cord injury the patient may also be experiencing numbness, tingling and immobility in the extremities. <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none">a. Monitor and maintain patient's airway, especially if patient is nauseated or vomiting.b. Allow patient to assume a comfortable position. Do not move the patient if a spinal cord injury is suspected due to the mechanism of injury and in cases of shallow water diving incidents.c. If the patient is in the water and breathing, support the patient there until help arrives to remove the patient from the water.d. Treat for shock:<ul style="list-style-type: none">1) Keep airway clear.2) DO NOT GIVE FOOD OR DRINK.	<p style="text-align: center;"><TG PAGE 3-117></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> 3) Let patient assume position of comfort. 4) Calm and reassure patient. 5) Keep the patient warm (maintain body temperature). e. Call back if the patient's condition changes before help arrives. f. If patient is found to be unconscious and not breathing proceed immediately to CPR treatment sequence and initiate CPR. g. Lock all pets away because they may interfere with instructions given or attack responding personnel. 5. Special Pediatric Considerations: <ul style="list-style-type: none"> a. Drowning is a major cause of unintentional death in young children. Near-drowning, or submersion injury followed by survival, is one critical pediatric emergencies for which you may receive calls for help. For these calls, field management is vital. The real window of opportunity for medical intervention is in the hands of the bystander, EMD, and EMS responders in the field. b. The injury in near drowning is global oxygen deficit. The goal of treatment is to reverse that deficit with rapid, effective airway support, rescue breathing and other advanced airway management techniques. 	<p><TG PAGE 3-118></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> c. Although children are given rescue breathing at lower volumes and pressure than adults, wet lungs are stiffer and harder to move. In giving bystanders pre-arrival instructions, make sure that the chest is moving. d. Vomiting is common in submersion victims and can complicate the airway support, particularly if it is not anticipated. e. Children are more likely than adults to continue to lose body heat when wet, even in warm weather. Replacing wet clothes if possible will minimize heat loss. f. Near-drowning, like most other critical pediatric injuries, is best managed with prevention. Restricting unsupervised access to known water hazards, promoting swimming lessons and teaching bystander CPR are some primary and secondary prevention strategies that EMS systems can advocate. 	<p><TG PAGE 3-119></p>
<p>5 - Electrocutation (Time/Life-Critical Event)</p> <ul style="list-style-type: none"> 1. Background: <ul style="list-style-type: none"> a. All electrocutions should be considered cardiac arrests until proven otherwise. b. Often falls are associated with electrocutions. Always consider the possibility of a long fall. 	<p>Review the Electrocutation complaint type.</p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">c. The primary concern should be gathering information regarding the safety of the scene and protecting the bystanders by advising them to beware of electrical risks and protecting the rescuers by relaying information about scene safety.d. Electrocutions are often associated with internal burns.e. All electrocutions should be considered high level emergencies. <p>2. Common Causes:</p> <ul style="list-style-type: none">a. Industrial accidents, electrical and utility workers electrocuted by coming in contact with high voltage wires. These are often associated with long falls. Always consider the possibility of other associated trauma as a result of the fall, and take spinal precautions.b. Construction accidents.c. Household accidents associated with electrified water.d. Lightning strikes. <p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none">a. Cardiac arrest.b. Burning sensation or surface burns at contact point. Also there may be burns at the point of grounding.c. Cardiac related problems.	<p><TG PAGE 3-120></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none">a. Advise the caller to not come in contact with the electrical source and to beware of electrified water. The caller may attempt to disconnect the electrical source if safe to do so.b. Monitor and maintain patient's airway, especially if patient has a lowered level of consciousness.c. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD.d. Treat for shock:<ul style="list-style-type: none">1) Keep airway clear.2) DO NOT GIVE FOOD OR DRINK.3) Let patient assume position of comfort.4) Calm and reassure patient.5) Keep the patient warm (maintain body temperature).e. Do not move the patient if a fall is involved.f. Call back if the patient's condition changes before help arrives.g. Contact with appropriate utility to secure the scene should be made as soon as possible. This includes P.D. and Fire Department for traffic control and scene control of downed wires in the case of traffic accidents.	<p style="text-align: center;"><TG PAGE 3-121></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>h. Lock all pets away because they may interfere with instructions given or attack responding personnel.</p> <p>5. Special Pediatric Considerations: - NONE</p> <p>6 - Pregnancy/Childbirth (Time/Life-Critical Event Type)</p> <p>1. Background:</p> <p>a. Gestation encompasses three trimesters or time periods. The first trimester includes months 1, 2 and 3. The second trimester includes months 4, 5, and 6. The third trimester includes months 7, 8, and 9.</p> <p>b. As the pregnancy progresses the severity of complications increases for both the mother and the child.</p> <p>c. Bleeding and other complications that occur during the first seven months of the pregnancy usually represent a miscarriage situation.</p> <p>d. Often the chief complaint will not be related to the pregnancy. If there seems to be no relationship with the pregnancy, the appropriate chief complaint protocol should be accessed, even if the caller informs you of the pregnancy.</p> <p>e. Pregnancy is a condition, not an illness.</p>	<p>Review the Pregnancy/Childbirth complaint type.</p> <p><TG PAGE 3-122></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> f. Pregnancy complications in the first and second trimesters, along with vaginal bleeding situations related to gynecological problems, should be handled symptomatically. Usually this requires treatment for shock. g. An imminent birth is defined as any prima gravida woman in her third trimester (first child) with labor pains less than two minutes apart. Any multigravida woman (second + third child) having labor pains less than five minutes apart should be considered an imminent birth as well. h. An imminent birth situation also exists if any part of the baby is showing or the mother complains that the pains are constant and/or she has the urge to push. <p>2. Common Causes:</p> <ul style="list-style-type: none"> a. Gynecological complaints most often reported include unusually heavy menstrual bleeding or untimely vaginal bleeding. b. Pregnancy related problems included in the first or second trimester usually relate to vaginal bleeding or abdominal pain. c. Imminent births include complaints of labor pains as described above, constant labor pains and/or baby parts showing. <p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none"> a. Untimely vaginal bleeding with associated shock symptoms. 	<p style="text-align: center;"><TG PAGE 3-123></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> b. Onset of labor, water breaking, etc. c. Imminent birth as defined above. <p>4. Instructions Commonly Provided:</p> <p>FOR CHILDBIRTH:</p> <ul style="list-style-type: none"> a. Do not try to prevent the birth by holding the legs together or crossing the legs. b. Have mother remove all clothing below the waist. c. Get mother on the bed or floor and prop her back up with pillows. d. Have mother take deep breaths during the pains and try not to push. e. Follow specific childbirth pre-arrival instruction scripts as written in the approved EMDPRS. <p>FOR PREGNANCY PROBLEMS:</p> <ul style="list-style-type: none"> a. The most common complaint related to pregnancy problems is untimely vaginal bleeding and associated abdominal pain. Symptoms of shock may be described by the caller as pallor, dizziness or lowered level of consciousness, chills, diaphoresis (sweating). b. Treat for shock: <ul style="list-style-type: none"> 1) Keep airway clear. 2) DO NOT GIVE FOOD OR DRINK. 	<p><TG PAGE 3-124></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>3) Let patient assume position of comfort.</p> <p>4) Calm and reassure patient.</p> <p>5) Keep the patient warm (maintain body temperature).</p> <p>APPLICABLE TO BOTH:</p> <p>a. Monitor and maintain patient's airway, especially if patient is nauseated or vomiting or if the level of consciousness is decreased.</p> <p>b. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD.</p> <p>c. Treat for shock:</p> <p>1) Keep airway clear.</p> <p>2) DO NOT GIVE FOOD OR DRINK.</p> <p>3) Let patient assume position of comfort.</p> <p>4) Calm and reassure patient.</p> <p>5) Keep the patient warm (maintain body temperature).</p> <p>d. Gather or list the patient's medications for the doctor.</p> <p>e. Call back if the patient's condition changes before help arrives.</p> <p>f. Lock all pets away because they may interfere with instructions given or attack responding personnel.</p>	<p><TG PAGE 3-125></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>5. Special Pediatric Considerations:</p> <p>a. The pregnant child (under 16) is more likely than an older woman to have become pregnant under circumstances of coercion, rape, incest, or under the influence of drugs or alcohol. She may have sought unusual means to terminate the pregnancy. Some states allow for protection of confidentiality to pregnant minors; consult your local regulations in this regard.</p>	
<p>7 - Unconscious/Fainting (Time/Life-Critical Event)</p> <p>1. Background:</p> <p>a. Unconsciousness denotes a state of consciousness from which an individual cannot be aroused, even with painful stimulation.</p> <p>b. A fainting episode denotes a situation from which an individual has previously fainted and has now awakened.</p> <p>c. Single fainting episodes (such as a syncopal episode where the patient faints and then returns to a normal consciousness level) are not considered generally to be high level emergencies, though you should treat all faintings with respect until you are certain there is no immediate danger.</p> <p>d. Multiple fainting episodes are considered to be more serious.</p> <p>e. The primary function of this protocol is to ensure that the patient has an open airway and that it is maintained until help arrives (airway control).</p>	<p>Review the Unconscious/Fainting complaint type.</p> <p><TG PAGE 3-126></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>f. This protocol should be used when there has been a faint or if the patient is unconscious and the caller does not know why. If the patient is an unconscious diabetic, or seizure patient, the EMD should utilize those protocols specifically.</p> <p>2. Common Causes:</p> <p>a. Stroke, diabetes, cardiac arrest, overdoses, poisonings, intoxication, head injuries, hypoxia, seizures, simple fainting episodes, shock and heart rhythm problems (too slow or fast).</p> <p>b. Conceivably anything that effects the brain in a negative way can render the patient unconscious.</p> <p>3. Common Symptoms Described by Caller (presentation)</p> <p>a. Fainting episode or episodes of unconsciousness for unknown reasons.</p> <p>4. Instructions Commonly Provided:</p> <p>a. Monitor and maintain patient's airway, especially if patient is nauseated or vomiting or if the level of consciousness is decreased.</p> <p>b. Lay patient on his back and monitor respirations. Turn patient on their side if vomiting occurs.</p> <p>c. DO NOT PLACE PILLOW UNDER PATIENT'S HEAD.</p>	<p style="text-align: center;"><TG PAGE 3-127></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>d. Treat for shock:</p> <ul style="list-style-type: none">1) Keep airway clear.2) DO NOT GIVE FOOD OR DRINK.3) Let patient assume position of comfort.4) Calm and reassure patient.5) Keep the patient warm (maintain body temperature). <p>e. Gather or list the patient's medications for the doctor.</p> <p>f. Call back if the patient's condition changes before help arrives.</p> <p>g. Lock all pets away because they may interfere with instructions given or attack responding personnel.</p> <p>5. Special Pediatric Considerations:</p> <p>a. Fainting or unconsciousness in the pediatric patient can be similar to the adult patient in underlying cause and degree of severity. However, there are several special circumstances to consider. In the infant, Apparent Life Threatening Events (ALTE) may occur from all the same causes mentioned in the general discussion, as well as from washing of stomach contents up the esophagus (reflux), unsuspected or unreported child abuse, serious bacterial infection and primary apnea (stopping breathing) related to immature respiratory reflexes. Usual reported symptoms will include limpness or stiffening, unresponsiveness, pallor or</p>	<p><TG PAGE 3-128></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>blue spell, which resolve either spontaneously or with attempts at resuscitation or stimulation. All such infants should be evaluated promptly regardless of how</p> <p>b. Infants and toddlers are subject to a particular kind of breath-holding spell that is very alarming to witness but usually self-limited. Typically the toddler will become angry or distressed about something and while crying suddenly hold his or her breath, sometimes to the point of unconsciousness, turning blue and possibly resulting in seizures. The hallmark of these episodes is that they occur while the child is crying and resolve on their own after a matter of seconds. A second variety of breath-holding in toddlers and young children is related to the fainting adults have when witnessing a distressing event. This spell usually occurs when the child turns pale and becomes unresponsive after a sudden but trivial injury. Both varieties may be difficult to distinguish from more concerning problems unless the child has done this in the past.</p>	<p><TG PAGE 3-129></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>Summary</p> <p>This unit has trained you on the medical content and design of the thirty-two chief complaint types. You have learned about the three types of complaints, and have been trained on the use of your local EMDPRS protocol.</p> <p>Next, you will complete the course by taking part in a final examination. The exam is comprehensive. It covers all material taught in this course. There will be role-play scenarios where you will be evaluated on your ability to use the knowledge you have gained.</p>	<p>Review the unit. Ask for (and answer) trainee questions.</p>

PRESENTING THE 32 CHIEF COMPLAINT TYPES

Helpful Hints:

The protocols should be separated into three groups and taught in the order of traumatic incident types first, medical complaints second and then the time/life-critical events. This approach is helpful because each grouping of incident types has a different focus during caller interrogation.

Approximately 15-20 minutes can be spent on each protocol as a rule, longer for some, less for others. There are many videos available that demonstrate dispatcher interventions in cardiac arrest, choking and childbirth situations that are very useful in lecture. You might want to check with the guidance committee (or medical director) to see if any of these are available, or if they could be purchased.

After discussing each section of chief complaint types, trainees should have about one hour of practical scenario role playing in which each student has the opportunity to be the caller and the dispatcher. This should be a supervised role play session with no more than 5-6 students in a group. Additional instructors are useful during this time if there are more than 3 or 4 groups.

Present the Chief Complaints in the Following Order:

Traumatic Incident Types

- 1) Animal Bites
- 2) Assault
- 3) Burns
- 4) Eye Problems
- 5) Fall Victim
- 6) Heat/Cold Exposure
- 7) Hemorrhage/Laceration
- 8) Industrial Accidents
- 9) Stab/Gunshot Wound
- 10) Traffic Accident
- 11) Traumatic Injury

MODULE 3 - IG NOTE #1

Basic Emergency Medical Dispatch Concepts

Medical Chief Complaint Types

- 1) Abdominal Pain
- 2) Allergies
- 3) Back Pain
- 4) Chest Pain
- 5) Breathing Problems
- 6) Convulsions/Seizures
- 7) Diabetic Problems
- 8) Headache
- 9) Heart Problems
- 10) Ingestions/Poisonings
- 11) Psychiatric Problems
- 12) Sick Person
- 13) Stroke/CVA
- 14) Unknown Problem/Man Down

Time/Life-Critical Events

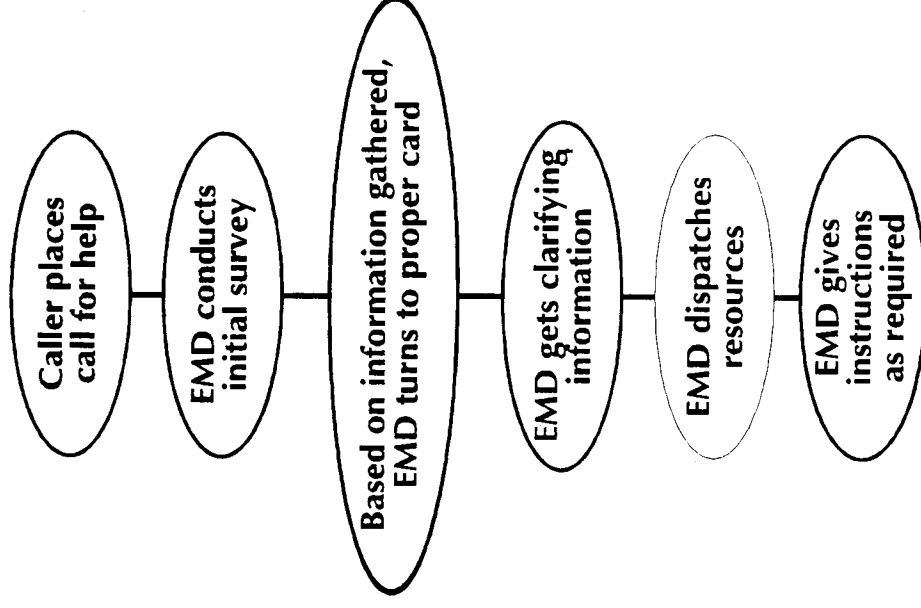
- 1) CO Poisoning/HAZMAT
- 2) Cardiac Arrest
- 3) Choking
- 4) Drowning
- 5) Electrocution
- 6) Pregnancy/Children
- 7) Unconscious/Fainting

For Each Chief Complaint Discuss:

For every chief complaint, consider discussing the protocols in this order:

- Background;
- Common causes;
- Symptoms frequently reported by callers;
- Instructions commonly given to callers;
- Common pediatric considerations (if any) and
- then review the local EMDPRS protocol regarding the complaint.

Flow of Call Processing



Individual Chief Complaints

- ▶ *Based on acute or chronic biological illness*
- ▶ *Proper responses based on...*
 - *chief complaint*
 - *patient's age*
 - *priority symptoms identified*
 - *relevant medical history*

Traumatic Incident Types

- ▶ *Based on some physical injury due to accident or violence*
- ▶ *Responses based on...*
 - *mechanism of injury*
 - *location of injury (core or extremity?)*

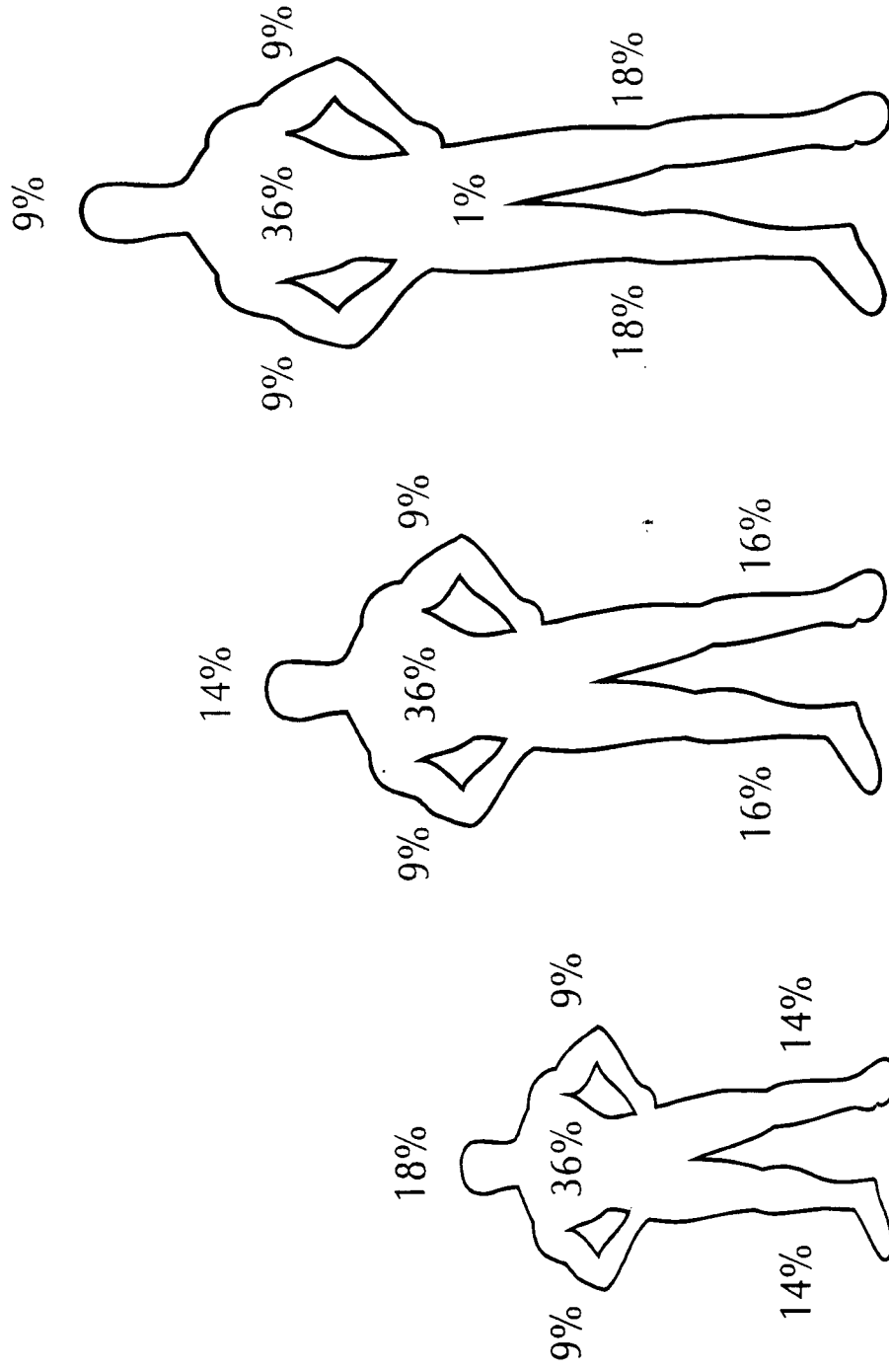
Time/Life-Critical Events

- ▶ *Pose greatest danger to patient, bystanders or responders*
- ▶ *Responses based on...*
 - *scene safety information*
 - *police, fire, HAZMAT, etc. needs*

EMDPRS Determines...

- ▶ *Order of EMD actions*
- ▶ *When to dispatch resources (types and configurations included)*
- ▶ *Assigns mode and configuration to responding personnel*
- ▶ *Tells when to give telephone medical instructions*
- ▶ *Tells when/how to end the call*

Rule of Nines



1 year old

5 years old

Adult

3-2-6

MODULE 4
Practical Examination

TRAINEE TEXT	INSTRUCTOR NOTES
<div data-bbox="345 487 704 535" style="border: 2px solid black; padding: 5px; margin-bottom: 20px;"> MODULE OVERVIEW </div> <p>Module 4 is the final practical exam for the NHTSA EMD training curriculum. You will demonstrate the proper and effective use of the knowledge that you have gained throughout this course.</p> <p>The practical exam will assist the instructor(s) in determining your readiness for the job of emergency medical dispatcher. As a result, you will likely be asked to demonstrate proficiency in all areas of EMD in a comprehensive format. You should be prepared to deal with all thirty-two chief complaint types. You will be tested, however, on only sixteen "real-life" simulations. These scenarios are conducted between the instructor and you, or you may be asked to participate in acting out a scenario with another trainee as the instructor(s) observe you. The instructor will decide on which types of complaints you will be tested.</p>	<div data-bbox="963 487 1209 535" style="border: 2px solid black; padding: 5px; margin-bottom: 20px;"> <TG PAGE 4-1> </div> <p>Introduce the Module. Describe what will happen during the final exam.</p>
<div data-bbox="345 1260 704 1310" style="border: 2px solid black; padding: 5px; margin-bottom: 20px;"> MODULE OBJECTIVES </div> <p>Upon completion of this module, you will:</p> <ol style="list-style-type: none"> 1. Demonstrate effective and proper EMD behaviors. 	<p>State the module objective(s).</p>

MODULE 4
Practical Examination

MODULE 4

Practical Examination Instructor Preparation

A final exam must be developed for this course by your local medical control and/or your local EMD guidance committee. All exams should be representative of the local training you are providing. The exam should cover medical and legal concepts as well as EMD specific material. Questions about the development of the final examination should be addressed to your local medical control and/or to your local EMD guidance committee.

1. Be sure to have all scenarios, audio/video tape and other testing materials ready prior to testing.

MODULE 4
Practical Examination Instructors Preparation

MODULE 4

Practical Examination Overview

TRAINEE TEXT	INSTRUCTOR NOTES
<div data-bbox="220 443 615 504" data-label="Section-Header"> <h4>EXAM OVERVIEW</h4> </div> <p data-bbox="228 554 948 694">The NHTSA course practical examination will consist of simulated or scripted calls for emergency medical assistance. You will be assessed on 16 of the 32 chief complaint types.</p> <p data-bbox="228 731 837 836">You will be assessed on your knowledge and demonstration of the skills required for effective dispatch including:</p> <ol data-bbox="228 873 922 1365" style="list-style-type: none"> 1. Proper telephone techniques; 2. Proper handling of difficult callers; 3. Proper use of EMDPRS to elicit dispatch information; 4. Proper use of the EMDPRS to allocate resources based on use of information gathered; 5. Proper identification of medical emergencies and 6. Proper delivery of medical instructions from the EMDPRS. <p data-bbox="228 1498 932 1745">Simulations and scripted role plays will be based on actual 9-1-1 calls. Actual 9-1-1 calls will be used to develop these simulations. Transcriptions might be used when available and cost effective. In either case, caller identification information contained in the calls will be removed and replaced with false data to protect the identity of the callers.</p>	<p data-bbox="992 443 1211 476"><TG PAGE 4-3></p> <p data-bbox="992 554 1422 589">Introduce the final examination.</p> <p data-bbox="992 731 1386 803">Tell trainees what they will be evaluated on.</p> <p data-bbox="992 873 1073 908">NOTE</p> <p data-bbox="992 947 1422 1463">You will need to develop a written exam and practical exam as final examination(s) for this course. All exams should be representative of the <u>local</u> training you are providing. The exam should cover medical and legal concepts as well as EMD specific material. Questions about the development of the final examination should be addressed to the local medical control and/or to the local EMD guidance committee.</p>

MODULE 4

Practical Examination Overview

TRAINEE TEXT	INSTRUCTOR NOTES
<div>EXAM OBJECTIVES</div> <p>Final Exam Terminal Objective</p> <p>Upon completion of this exam, you will be able to:</p> <ol style="list-style-type: none">1. Demonstrate effective and proper EMD behaviors.	<p>State the exam learning objective(s).</p>